Report to the Legislature

Evidence-based and Research-based Practices
Strategies, Timelines and Costs

2013 Legislature, E2SHB 2536

December 30, 2013

Department of Social and Health Services

Behavioral Health and Service Integration Administration

Children's Administration (CA)

Juvenile Justice and Rehabilitation Administration (JJ&RA)

and

Health Care Authority (HCA)

P.O. Box 45050 10th Ave SE
Olympia, WA 98504-45050

Executive Summary

This report was requested by the Legislature to examine the expansion of Evidence-based and Research-based practices (E/RBPs) within the state-run systems serving children and youth in Washington and to recommend Strategies, Timelines and Costs in this effort.

This multi-system review of use of E/RBPs highlights successful implementation as well as improvement opportunities within each system. In addition, common challenges in reaching the legislative goal of substantial increases in the use of E/RBPs are described.

Areas that will require additional attention include E/RBP fidelity monitoring; increased costs of E/RBP services; on-going training; data/quality assurance; and the addressing the unique needs of Medicaid and Tribal populations.

This report shows the work that has begun within child serving systems to meet the intent of E2SHB 2536. It should be noted that increased and sustained implementation of E/RBPs will require new infrastructure investments. It is recommended that the legislative and executive branches continue to focus on:

- Flexible fidelity monitoring that focuses on improving outcomes for children and youth served;
- Cost implications of ongoing implementation, including training, for providers delivering E/RBPs;
- Quality Assurance/Improvement with a focus on improving outcomes by enhancing data collection and analysis to inform decisions and future direction; and
- Promising practices that meet the needs of special populations.

A great deal of work still needs to be done to accomplish the legislature's intent that mental health, child welfare, and juvenile justice services delivered to children and youth be primarily evidence-based and research-based. The child-serving agencies are committed to continuing the work with adequate infrastructure funding.

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Introduction

In accordance with E2SHB 2536, the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) present this report on recommended strategies, timelines, and costs for increasing the use of evidence-based and research-based practices across the child serving systems of child welfare, juvenile justice, and children's mental health services. The assessment includes prevention and intervention services provided through Medicaid fee-for-service and Healthy Options managed care contracts. The report includes recommendations for:

- Substantial increases in Evidence Based (EBP) and Research Based Practices (RBP) (collectively E/RBPs) throughout Washington's Child Serving Systems.
- Strategies to identify effective E/RBPs, particularly those addressing ethnically diverse communities, Native American/American Indian tribes, and rural areas.
- Strategies, timelines and costs for increasing use of E/RBPs, and distinguishing between the reallocation of existing funds and new funds needed to increase the use of these practices.
- Substantial increases in the use of E/RBPs for the 2015-2017 and 2017-2019 biennia.

The report provides information regarding how DSHS Behavioral Health and Service Integration Administration's (BHSIA's) Division of Behavioral Health and Recovery (DBHR), Children's Administration (CA), juvenile courts, the Juvenile Justice and Rehabilitation Administration's (JJ&RA) Juvenile Rehabilitation, and the Health Care Authority (HCA) plan to increase the use of evidence based, research based and promising practices.

While Tribal Governments are open to the idea of implementing E/RBPs, they reserve the right as sovereign nations to be exempt from E/RBP legislative requirements. Their concern is based on the fact that there have not been a sufficient number of E/RBPs normed for American Indian and Alaska Native populations.

Background

Behavioral Health and Service Integration Administration/Division of Behavioral Health and Recovery/Children's Mental Health

Over the last decade, initiatives, litigation and legislation, have provided direction for improvements to the children's mental health system. Second Substitute House Bill 1088, passed in 2007, provided clear policy direction for the children's mental health system to increase its utilization of evidence-based practices. The legislation established the University of Washington Evidence-Based Practices Institute (EBPI) and directed DSHS to contract with the EBPI for the implementation of a wraparound model of integrated children's mental health service delivery in up to four Regional Support Networks (RSNs) in Washington State. The 2012 passage of E2SHB 2536 provides direction regarding increasing evidence-based and research-based mental health services in child-serving systems. Additional drivers for improvements to the children's mental health system include the settlement agreement for T.R. vs. Kevin Quigley and Dorothy Teeter, federal grant requirements (System of Care and Creating Connections), and quality improvement efforts targeted at residential treatment and its place in the continuum of care.

Since 2006, DBHR has implemented and assisted RSNs and providers with developing and implementing the following evidence-based programs that are identified on the *Inventory of Evidence-Based, Research-Based, and Promising Practices* prepared by WSIPP:

- Trauma Focused – Cognitive Behavioral Therapy (TF-CBT)
- Cognitive Behavioral Therapy (CBT) for Anxious children
- Cognitive Behavioral Therapy (CBT) for Depressed children
- Cognitive Behavioral Therapy (CBT) for Behavioral Problems
- Wraparound (for youth involved in multiple child serving systems)
- Dialectical Behavior Therapy (DBT)
- Multi-Dimensional Treatment Foster Care (MTFC)
- Multi-Systemic Therapy (MST)

DBHR has and will continue to fund training for RSNs and Community Mental Health Agencies on specific E/RBPs and fidelity reviews. Additional resources will be utilized in the years to come.

Children's Administration

The DSHS Children's Administration (CA) began implementing evidence-based practices (EBPs) in 2005, and has been committed to expanding the number and scope of evidence-based practices since that time. CA began purchasing evidence-based and research-based practices, along with fidelity monitoring, in 2006. CA has implemented evidence-based and research-based practices consistent with the 2003 Washington State Institute for Public Policy's (WSIPP) conclusion that evidence-based practices must be implemented with on-going quality assurance (i.e. fidelity monitoring) to achieve the researched outcomes. CA currently purchases seven evidence-based and research-based practices that are identified on the *Inventory of Evidence-Based, Research-Based, and Promising Practices* prepared by WSIPP in 2012:

- Functional Family Therapy
- HomeBuilders
- Incredible Years
- Multi-Dimensional Treatment Foster Care
- Parent Child Interaction Therapy
- SafeCare
- Triple P – Level 4, Pathways, and Teen

Juvenile Justice

The Washington State juvenile justice system has been utilizing E/RBPs since the mid-1990s. The Juvenile Justice and Rehabilitation Administration's (JJ&RA) Juvenile Rehabilitation's (JR) first use of research-based practices was a small scale implementation of mentoring and Dialectical Behavioral Therapy (DBT).

In 1997, the Washington State Legislature began to significantly invest in juvenile justice evidence-based programs by passing the Community Juvenile Accountability Act (CJAA). WSIPP, in collaboration with the juvenile courts and JR, identified a range of effective approaches that cost-effectively reduce juvenile offender recidivism. All of the programs identified at that time are still being utilized within the juvenile courts today.

The Juvenile Rehabilitation (JR) and Juvenile Courts continually improve this system. In 2002, JR implemented a new parole model based on the core elements of Functional Family Therapy (FFT) called Functional Family Parole (FFP). In 2003, as recommended by WSIPP, program quality assurance was developed and implemented to ensure individual treatment programs were being delivered with fidelity. The juvenile justice system continues to adapt as the needs of our clients have changed. As a result of a growing trend of youth with co-occurring substance abuse and mental health disorders in the juvenile justice system, the Family Integrated Transitions (FIT) program was added to the menu of program options for JR in 2002 and in the juvenile courts in 2008.

The following juvenile rehabilitation and county courts programs were included in the state fiscal year 2012 baseline assessment:

- Aggression Replacement Training (ART)
- Coordination of Services (COS)
- Dialectical Behavior Therapy (DBT)
- Functional Family Parole (FFP)
- Functional Family Therapy (FFT)
- Family Integrated Transitions (FIT)
- Multi-Dimensional Treatment Foster Care (MDTFC)
- Multi-Systemic Therapy (MST)

Health Care Authority

The Health Care Authority administers a limited Medicaid benefit that covers mental health services for children 18 years of age and younger. It includes:

- Up to 20 visits for counseling with the option for additional visits through the prior authorization process. *(In expanding application of the Mental Health Parity and Addiction Equity Act, the Affordable Care Act requires that these treatment limitations be removed effective January 1, 2014)*;
- As defined in **RCW 71.34.020**, licensed by the Department of Health (DOH), and as allowed under the Indian Health Care Act (IHCIA), mental health professionals providing services within a tribal setting include:
    - Psychologists
    - Psychiatric Advanced Registered Nurse Practitioners (ARNP)
    - Licensed Independent Clinical Social Workers
    - Licensed Marriage and Family Therapists
    - Licensed Mental Health Counselors (Must certify they have two years of experience working with children before being enrolled as a Medicaid provider)
- Unlimited visits by a psychiatrist
- Unlimited visits for medication management by a psychiatrist or psychiatric ARNP
- Psychological and neuropsychological testing

The following mental health services are also available for children 19 and 20 years of age:

- 12 visits per year by a psychiatrist with the option for additional visits through the prior authorization process *(In expanding application of the Mental Health Parity and Addiction Equity Act, the Affordable Care Act requires that these treatment limitations be removed effective January 1, 2014)*

- Additional services as needed under Early Period Screening Diagnosis and Treatment (EPSDT)

Although the limited Medicaid mental health benefit administered by the HCA does not require that mental health services provided be E/RBPs, Medicaid covers the following evidence based services:

- Functional Family Therapy (FFT)
- Partnership Access Line (PAL)
- Second Opinion Network (SON)
- Positive Parenting Program (Triple P)

Components of successful implementation of E/RBPs

When implementing a successful evidence-based or research-based practice, model fidelity is essential. Fidelity, or quality control standards, demands prescribed structure and replication with an overall goal of effective and positive outcomes. WSIPP found that when programs do not adhere to the original design, they can fail. Juvenile justice programs can actually increase the recidivism rates of participants when they are delivered poorly (Aos, 2004)(Barnoski, 2004). When providers stray from an E/RBP model over time, the beneficial results of the E/RBP tend to be reduced (Schoenwald, et al, 2000) (e.g., Schoenwald, Henggeler, Brondion, and Rowland, 2000).

Implementation and sustenance of E/RBPs will take dedicated financial support. Initial implementation requires scaling up capabilities to deliver E/RBPs, including provider training. Ongoing costs are associated with monitoring fidelity, feedback, coaching and support to providers and ongoing training associated with staff turnover (Aarons, Hurlburt, McCue Horwitz 2010).

Key areas requiring focused attention from the legislature include:

- **Expansion**—Substantially increasing E/RBPs in child serving systems incurs resources that have not yet been allocated. Expansion is resource-intensive and requires ongoing education as staff turnover occurs regularly. To date, DSHS and HCA have directed providers to increase E/RBPs but have not provided compensation for the necessary systematic change in operations. This has led to dollars being taken away from direct service and shifted to administrative costs. This shift impacts the quality of care provided to children/youth within these child serving systems.
- **Community Inclusion**—It is essential to include stakeholders, governments, providers, courts and children/youth and families as we expand implementation of E/RBPs in Washington State.
- **Quality Assurance and Fidelity**—There are no dedicated funding streams for E/RBP quality assurance and fidelity monitoring. Paradoxically, this has resulted in the shifting of funding away from direct client services. Dedicated funding for quality assurance and fidelity monitoring would ensure that access to direct client services to children/youth would not suffer in the effort to sustain E/RBPs. More children/youth would be served and positive outcomes would be enhanced.
- **Research**—Data informed decisions should drive decisions about which new E/RBPs to implement. A lack of regular and continued research and evaluation will lead to a system that will become outdated, unresponsive to new trends, and in turn, be less successful in assisting the individuals we serve.
- **Promising Programs**—Moving toward increased E/RBPs in Washington has revealed that a gap in services for specific populations and diagnoses may still exist. To effectively implement promising programs, new funding will be needed for research, data analysis, quality assurance and fidelity monitoring.

Community and Tribal Government Feedback regarding E/RBP implementation

Community feedback

Issues that have been identified across communities are:

- **Cost**—There is a great deal of concern around the uncompensated cost associated with increasing the availability of E/RBPs within DSHS and HCA provider systems. The costs related to training and maintaining these services were not taken into consideration in the initial legislation.
- **Fidelity**—Stakeholders have expressed the need for increased and improved guidance, support, and financial infrastructures to support the ongoing task of fidelity monitoring. Because there is no funding allocated to fidelity costs, many administrations use direct service funding to purchase fidelity and quality assurance.
- **Lower caseloads**—Mental health providers have shared that particular E/RBP programs mandate client to practitioner ratios and rigid fidelity requirements. Lower caseload threshold decreases provider productivity and impacts their compensation negatively.
- **Informed by Cultural and Ethnic Diversity**—Stakeholders are concerned that not enough focus has been given to the cultural appropriateness of E/RBPs. The Department plans to work with model developers in examining, adapting and/or exploring promising practices. Work needs to continue with increased engagement of youth and families, experts in diverse communities and the Family Youth System Partner Round Tables (FYSPRTs) throughout the process. Recruiting a diverse workforce able to effectively deliver services and meet the needs of diverse populations in the communities we serve is also required. This includes the ability to respect and serve families where there is diversity in religion, sexual orientation, gender identity and expression, language, race, ethnicity, urban/rural, socioeconomic and culture.
- **Understanding a unique population**—Programs and delivery systems may be created without taking into consideration the uniqueness of sub populations and the unintended consequences of disproportionality.
- **Accessibility**—To the greatest extent possible, DSHS and HCA strive to allow E/RBP access to all children/youth across the state of Washington. Currently, it is difficult to identify and retain sufficient numbers of culturally responsive and highly qualified therapists to serve remote and rural areas of the state.

Tribal Governments Feedback

In honoring the unique government to government relationship between the State of Washington and Tribal Governments and Recognized American Indian Organizations, DSHS and HCA have consulted formally with the tribes. The following is a summary of the information shared by the Tribal leaders during the consultation process:

Tribes indicated there are limited evidence-based, research-based and promising practices that have been tested in tribal communities. The range of Washington's tribal communities (urban, rural and frontier) adds another level of complexity to finding E/RBPs that have been adequately normed for tribal communities. What is known is that a cookie-cutter approach to services does not work. E/RBPs are expensive to implement and maintain. For any E/RBP to be effective, ongoing fidelity monitoring and technical assistance is necessary—this is an additional cost to actual service provision. Another conflict is with the primary funding streams Tribes use for providing behavioral health services, including Indian Health Services, Medicaid and tribal and state funding.

There needs to be an explicit acknowledgement that Tribes know what works best in a Tribal community and that a pilot project or study that works in one Tribal community may not necessarily be easily replicated in another. Each tribe in Washington has its own rich and unique history, culture and traditions.

Tribes also shared that E/RBPs are not a panacea. The Tribes have a strong interest in looking at current Tribal practices and pursuing them as promising practices. Through this process, they seek modalities that will fit within the current Tribal Health system and make adjustments as necessary to keep the core practice. In collaboration with the Tribes, DSHS and HCA will initiate discussions to explore implementing elements of effective E/RBP programs for tribal youth to ensure the research based components of the models will meet the cultural and spiritual aspects unique to each Tribe.

Opportunities and Challenges

Implementing changes within current practices not only takes commitment and time, but also comes with both unique and shared opportunities and challenges to each system within DSHS and HCA.

Opportunities:

- **Improved Outcomes**—Increasing E/RBPs allows for better outcomes for youth and families by decreasing recidivism, increasing safety, and increasing emotional well-being.
- **Consistency and Standards**—Working across DSHS and HCA allows all involved to move toward consistent standards for effective programs across the state.
- **Efficient use of tax payer dollars**—Investing in programs that are proven effective for the intended population ultimately leads to better outcomes—and cost savings.
- **Alignment between DSHS and HCA**—Improved alignment of training and quality standards between DSHS and HCA will increase efficiencies allowing extra resources for implementation, especially those to support practitioners in meeting the diverse needs of the families they serve.

Challenges:

- **Work force turnover**—Ongoing recruitment and training of providers increases costs. For example, Triple P training was provided in FY2013 to 20 providers. Six months later only 11 providers remained to provide the service.
- **Cost/resources**—It is difficult to assess the costs that will be incurred or created by the change in the service delivery system, other than the fact that there will be an increased need for resources with which to fund ongoing provider training, fidelity monitoring and data analysis.
- **Affordable Care Act**—An influx of additional clients with the implementation of the Affordable Care Act will impact provider availability.
- **Administrative Staff**—Increased administrative resources are required to manage service delivery system changes (e.g., contracts, payments, teaching, fidelity monitoring) at all levels of DSHS and HCA and provider agencies.
- **Quality assurance**—Establishing a consistent, manageable and unified approach to Quality Assurance when working with E/RBPs will be difficult across four diverse and large systems (BHSIA, CA, JJ&RA and HCA) and multiple E/RBPs.
- **Complex Clients**—The complexities of the youth and families served may impact the prioritization of work set forth in this report due to the ebb/flow of the populations within the service structure and the multi-dimensional complexities of presenting issues of both the youth and families served.

Increasing Evidence/Research Based Practices: Strategies, Timelines and Cost

Behavioral Health and Services Integration Administration (BHSIA)

Implementation and Resources

With the introduction of E/RBPs, costs will increase during initial years of implementation. The exact dollar amount is difficult to project considering the changing landscape of both medical and behavioral health care. Certain fixed costs are associated with any E/RBP introduced into the service array. Adequate funding is critical to the success of the E/RBPs. Fixed costs include:

- Training
- Materials Manuals
- Re-training
- Monitoring practice (internal/external)
- Local implementation costs
- Adaptation for underserved populations and changing service climates
- Licensing fees
- Infrastructure implementation
- Staffing
- Analytical/Decision Support
- Ongoing supervision and coaching to a specific model (internal/external)

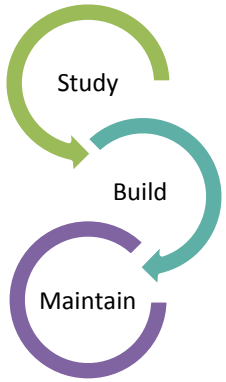
Since the majority of BHSIA/DBHR's behavioral health services are provided through the Regional Support Networks (RSNs), who subcontract with mental health agencies, it is important to understand the unique pressures an agency director faces when implementing changes that affect the day-to-day delivery of services. Agency directors look at many areas and how they affect their business model, including cost, while holding the standards of providing high quality services. These areas will be subject to discussion when the RSNs contract for public mental health with these agencies. For example:

- Does the E/RBP model have a manual that will fit the local culture and language?
- Is the purveyor of the E/RBP local to the area to provide assistance needed with implementation?
- Has implementation of a particular E/RBP taken into consideration the cost of 'non-billable hours'?
- Cost associated with economies of scale—larger areas will have an easier time implementing E/RBPs while smaller communities will struggle in meeting a mandate due to the low census of a community. In addition, time away to train can severely impact an agency with fewer clinicians.
- Licensing rules of certain E/RBPs can tie the hands of an organization due to the caseload size mandates—thus, leading to extra costs.

- The cost of working within a unionized work environment. Collective Bargaining Agreements mandate structures that may be cost prohibitive to agencies when working on adopting certain E/RBPs, or E/RBPs may require service staff outside of routine agreements.
- Examining the "true" cost of implementing and maintaining E/RBPs?

Understanding the costs related to implementation gives a glimpse into the possible overall cost increase in operationalizing many E/RBP within the current service delivery system for children's behavioral health services. Projecting future cost is difficult and does not truly represent the projected increased cost in the 2015-2017 and 2017-2019 Biennia.

A better understanding of the effects of increasing evidence and research based practice within DBHR requires a multi-phased effort across multiple biennia to make thoughtful and purposeful changes. This three phase process will allow DBHR to work collaboratively and broadly with its partners in creating an action plan and cost structure that will produce an effective, productive and sustainable effort.



Study—Examine the landscape of current services and 'gaps' within children's behavioral health and the 'true cost' impacts on provider agencies when implementing E/RBPs.
Build—Informed by the study, select, endorse and operationalize practices into the current service array to build capacity across the entire state.
Maintain—Develop a cost structure to fund implementation and sustainable support of needed infrastructure.

Study

By July 2014, DBHR, in partnership with the Evidence Based Practice Institute will conduct a 'Gaps Analysis' study to examine:

- Groups of individuals that are not being served
- The unique ethnic/cultural needs that require E/RBP adaptation
- Communities and geographical areas that do not have E/RBP services, e.g., rural and frontier communities
- Diagnostic categories that may not have E/RBP treatment modalities currently in place

DBHR and EBPI will also partner to conduct a 'True Cost' study within an RSN/provider system that will examine costs across phases of implementation, including:

- Exploration phase
  - Determining fit
  - Planning for initial implementation
- Initial implementation phase
  - Materials
  - Data systems
  - Updating forms

- Full implementation phase
    - Turn-over
    - Fidelity supports
    - Technical assistance
    - Marketing
    - Licensures
- Adaptation/sustainability phase
    - Cultural adaptations
    - Translations
    - Retraining due to staff or supervisor turn-over
    - Potential offsets and savings with increased use of E/RBPs

Cost considerations include the unique cost structure that drives service delivery within a provider system, the 'billable' and 'non-billable" tasks when implementing a program within an agency, economies of scale (e.g., shared costs, redirected costs, cross-trained staff) and the effects of metropolitan and rural settings. Other costs to be examined include the costs of associated activities (e.g., initial lower caseloads, source of training dollars, supervisor training, unions, workforce development, and any other unforeseen impacts on 'true cost', impact on employee turnover and productivity over time, reduced need for more intensive/expensive services over time and agency productivity.

Build

Upon completion of the "gap" analysis, DBHR, in partnership with the RSNs, will create an action plan addressing identified needs. E/RBPs will be selected or endorsed to meet the needs of identified underserved populations to ensure programs are available statewide.

The focus for Fiscal Years 2013-2014 is to continue to invest in increasing the availability of Wraparound and the four Cognitive Behavioral Therapies (Trauma, Anxiety, Depression and Behavioral Issues). The combination of these treatments has proven effective for the majority of children/youth in the RSN system and have been positively evaluated in a diversity of cultures, ethnicities, communities.

Maintain

In order for any evidence-based practice to be sustainable, it must be built into the Medicaid rates paid to the Regional Support Networks and CMHAs to provide the expected services, maintain a well-trained workforce, and monitor the standards set forth by the practice. DBHR intends to work with its actuary on an ongoing basis to build standards into the capitated payments for all Medicaid-eligible clients that will be sufficient to sustain the practice and embed the costs into the Medicaid benefit. This will maximize the ability to receive federal match for the established practice. Over time, training and monitoring, which by themselves are not eligible for Medicaid match funding, will be shifted to administrative costs and are then matchable through Federal Medicaid with an overall goal of achieving efficiencies.

Evidence Based Practices Expansion

At the time of the June 30, 2013, baseline report, DBHR was challenged with capturing data for the baseline assessment. Providers submit encounter data for services of Medicaid children's mental health clients in the Provider One System. Services were listed by the type of State Plan service provided, but not by the program utilized, such as evidence-based practice.

To enable better tracking of the number of E/RBPs utilized in the state and the number of children receiving these services, providers were asked to complete coding when entering data into their reporting

systems. This reporting system took effect in April 2013 and language has been added to Regional Support Network contracts to support the change in reporting to create a more reliable stream of data coming from providers. The table below (Table 1) captures the Children's Mental Health Evidence Based Practices as of August 30, 2013. As captured in Provider One, the percentage of RSN enrolled youth in EBP was 0.67 percent.

Table 1

Youth Mental Health Enrollment and Services in Evidence Based Practices by RSN
Consumers 20 years old and younger
Services between 7/1/2012 and 8/30/2013

RSN	# RSN Youth Clients (<=20 yrs) receiving any MH OP Service	# Youth (<=20 yrs) enrolled in an EBP	% of RSN Youth Clients enrolled in EBP	# Youth EBP Enrollees receiving MH OP service during enrollement	% of Youth EBP Enrollees receiving MH OP service
THURSTON	2,209	164	7.42%	115	70%
GREATER COLUMBIA	7,508	68	0.91%	54	79%
N. SOUND	6,846	55	0.80%	47	85%
GRAYS HARBOR	851	23	2.70%	15	65%
PENINSULA	1,943	11	0.57%	10	91%
SPOKANE	5,360	4	0.07%	4	100%
KING	10,964	4	0.04%	2	50%
CHELAN/DOUGLAS	1,375	2	0.15%	2	100%
CLARK	4,298	1	0.02%	1	100%
N. CENTRAL	1,164	0	0.00%	0	
S. W. (COWLITZ)	1,758	0	0.00%	0	
PIERCE	5,765	0	0.00%	0	
TIMBERLANDS	963	0	0.00%	0	
All RSNs	**49,549**	**332**	**0.67%**	**249**	**75%**

Source: DSHS-DBHR Consumer Information System (CIS) reporting database (Run Date: 09/18/2013).

NOTE: These numbers are based on 13 RSNs which existed at the time the services documented. Future reports will be based on the current structure of 11 RSNs.

With the addition of a more detailed reporting system within Provider One and reporting requirements within RSN contracts, there has been reluctance by providers and RSNs to use the new modifier codes due to the uncertainty of how "fidelity" to a model should be determined for certification purposes. The code definitions in the July 2013 Service Encounter Reporting Instructions (SERI) page 89 , state, *"…only services that are delivered with adherence to the researched program model should be reported using this procedure."* This language prevented many RSNs and/or providers from reporting their information as they did not feel comfortable certifying that the practices they are administering are being done with fidelity to the model that the State expects. DBHR and the RSNs are working to mitigate this concern but have not established a resolution at the writing of this report.

The current strategy of expansion of Evidence and Research Based Practices is:

- Strive to serve the majority of children/youth with an offering of an E/RBP within the RSN level of care.
- Focus on E/RBPs currently being offered and continue to expand the reach of the services across the state.
- Based on the 'Gap Analysis', continue to address and target areas to ensure that E/RBPs are consistently available statewide and continue to increase the number of children/youth served effectively.

Timeline

This legislation has provided DBHR with an opportunity to set attainable long term goals for Children's Mental Health improvement. We have set a goal of 45 percent of children/youth enrolled in a CMHA being treated with an E/RBP by the end of 2019. Undertaking this level of change will take both a concerted focus and resources for our provider network to implement the changes. It is a steady and incremental goal to allow the system to change gradually in a sustainable fashion as opposed to forcing a quick change that the system is currently not ready or able to absorb in an effective manner.

As indicated in table (A) DBHR has set out a six-year plan to increase the use of E/RBPs provided to children/youth by stepping-up the target by 15 percent each biennium (7.5 percent each year). The data pulled when working with table (A) will run from January through December. As indicated in Tabel (B), benchmarks will also be measured biennially. Looking at data at this level will allow DBHR to project and determine whether the goal will be reached or if adjustments must be made in practice, recording of date, reporting, or the goal itself.

Year	COB %
2014	7.5%
2015	15%
2016	22.5%
2017	30%
2018	37.5%
2019	45%

(Table A)

Biennium	COB %
2013-2015	15%
2015-2017	30%
2011-2019	45%

(Table B)

(Note: Projected increases for the current biennium are dependent on funding set forth in the TR vs. Quigley decision package as well as Federal Block Grant dollars.)

Children's Administration (CA)

Children's Administration will meet the requirement to substantially increase the use of evidence-based and research-based practices by:

1. Expanding the utilization of evidence-based and research-based practices currently used
2. Increasing the number of families that successfully complete the service in which they participate
3. Adopting new evidence-based or research-based practices

The June 2012 EBP Baseline Report identified the number of families CA serves and the funding spent on evidence-based and research-based practices. Since that report, CA has continued to work to increase the number of children and families provided an evidence-based or research-based practice. Projections for increasing the number of families served based on this continued effort are identified in Table 1.

CA recently identified that the rate of families completing the full evidence-based and research-based practice is around 45 percent collectively. It is CA's intent to deliver the right service, at the right time, for each family. When services are delivered at the right time based on the family's needs, the completion rate is expected to be higher. CA will be implementing strategies to better match families' needs with the right service, which are expected to increase the completion rate for evidence-based and research-based practices.

Additionally, CA reviewed the current contracted services provided to children and families that are not evidence-based or research-based to identify those intervention services where we could incorporate an evidence-based or research-based practice. There were no services where we could facilitate a simple change from the current service to an evidence-based or research-based practice. Several of the services do not have an evidence-based or research-based practice analog. There are some opportunities for migration to an evidence-based and research-based practice for the remaining services.

1. Expand Utilization of Current Evidence-Based and Research-Based Practices

Children's Administration will continue to expand the number of families served by the current set of evidence-based and research-based practices by:

- Relocating funds currently used to purchase non-evidence-based or non-research-based in-home services such as Family Preservation Services or parent education
- Maintaining CA staff support for this on-going effort.

Table 3: Goals for Increasing Use of In-Home and Reunification EBPs in FY2014

Practice	Participants Served FY2012 Baseline	Target Increase	Projected Participants FY2014
Functional Family Therapy	265	25%	330
HomeBuilders	558	5%	585
Incredible Years	100[1]	370%	470
Multi-Dimensional Treatment Foster Care (MTFC)	30	0%	30
Parent Child Interaction Therapy	155	25%	190
SafeCare	241	25%	300
Triple P	0	n/a	200[2]
Total	**1,349**	**56%**	**2,105**

These projected increases represent a combined 56 percent increase from the FY2012 baseline. CA anticipates achieving this increase with no change in MTFC (program is at maximum capacity) and with little change in HomeBuilders utilization.

[1] This is a best estimate of Incredible Years utilization, based on consultation with the fidelity monitor.

[2] Projection based on utilization of Triple P for last quarter in Fiscal Year 2013.

2. Increase Number of Families Who Successfully Complete the Service

The full effects of evidence-based and research-based practices are achieved when families complete the intervention. Approximately 50 to 60 percent of families referred for evidence-based and research-based practices complete the service. There are many factors impacting whether families will complete a service, such as:

- Match of the service to the family needs
- Cultural responsiveness of the therapist
- Success of the service in supporting child safety and placement of the child into out-of-home care
- Case closure before service ends

Children's Administration continues to identify new opportunities to support families getting the right service at the right time, and believe this to be critical in successful child and family outcomes. To achieve a higher service completion rate during Fiscal Year 2014, CA will focus on:

- Increasing supports to assist social workers in matching children and families' needs with the right service at the right time
- Working with contractors to increase the number of high quality and culturally respectful therapists able to serve CA children and families
- Monitoring the completion rate for each service and analyzing reasons for lack of completion

3. Adopt New Evidence-Based and Research-Based Practices

Children's Administration currently offers a number of services to children and families that meet the definition of an Intervention Service as identified in RCW 43.20C. Of those intervention services, some are targeted at a population and service need that aligns with an evidence-based or research-based practice that could be used instead of the current service. For other intervention services, CA was not able to identify any one evidence-based or research-based practice that could replace the current service. For example, MTFC would not meet the needs of all children placed in Behavioral Rehabilitation Services such as the needs of autistic or medically fragile youth.

Additionally, there are CA services where no evidence-based or research-based practice could be identified (e.g. Crisis Residential Centers or HOPE Program). Following the intent of the legislation, CA has identified opportunities where evidence-informed services may be used where no evidence-based or research-based practice has been found.

The services listed below are intervention services where no evidence-based or research-based practice equivalent could be found:

- Responsible Living Skills Program
- Independent Living Skills
- Pediatric Interim Care
- Sexually Aggressive Youth Services
- HOPE Program
- Crisis Residential Centers
- Street Youth Services

The services identified below are intervention services where an evidence-based, research-based, or evidence-informed practices have been identified that may meet the needs of some of the children and families referred for the service.

- Early Intervention Program
- Parent-Child Visitation
- Early Family Support Services
- Behavioral Rehabilitation Services – Treatment Foster Care Setting
- Behavioral Rehabilitation Services – Residential Care Setting
- Children's Hospitalization Alternative Program (CHAP)
- Child Placing Agencies
- Counseling Services

Recommendations

There are many opportunities for CA to increase the use of evidence-based or research-based practices. CA has been implementing evidence-based and research-based practices since 2005. During that time we have learned that successful implementation of evidence-based or research-based practices requires making choices that:

1. Directly support the administration's core mission
2. Have sufficient staff resources to support Contractors and CA case managers
3. Do not overwhelm CA case managers or Contractors with change

Based on these lessons learned, CA proposes the following expansion and increases for Fiscal Year 2014.

1. Expansion of Current Services: CA is able to reach this expansion within the funds currently appropriated.

Table 4: Current Service Expansion and Cost

Practice	Projected Participants FY2014	Additional Funding Needed to Achieve
Functional Family Therapy	330	None
HomeBuilders	585	
Incredible Years	470	
Multi-Dimensional Treatment Foster Care (MTFC)	30	
Parent Child Interaction Therapy	190	
SafeCare	300	
Triple P	200	
Total	**2,105**	

2. Increase Service Completion Rate: CA will seek to achieve a ten percent increase cumulatively over the current evidence-based and research-based practices completion rate. This increase can be achieved within current resources.

CA anticipates setting a baseline completion rate for each service. The cumulative completion rate will be based on Fiscal Year 2011. CA will seek a five percent increase in the cumulative completion rate for services delivered in Fiscal Year 2014.

3. Developing New Services: CA has identified the following services as the best opportunities to successfully and substantially enhance services identified in Table 5. CA anticipates these services will enhance our ability in meeting the core mission of the agency: safety, permanency, and child well-being.

Table 5: Proposed Services

Current Contracted Service	Potential Practice to be Incorporated	Anticipated Enhancement
Parent-Child Visitation	▪ Incredible Years Parent Coaching	▪ Parental skill development allowing for quicker reunification
Early Family Support Service (EFSS)	▪ Promoting First Relationships	▪ Increased parent empathy and skill development supporting young children to safely remain in their own home
Child Placing Agencies (CPA)	▪ KEEP	▪ Fewer placement disruptions ▪ Increased foster parent retention ▪ Increased support of children with behavior problems

CA will require additional funding to develop and implement these evidence-based, research-based, or research-informed practices, and the estimated funding necessary to implement the identified practice is identified in Table 6. The cost impact to adopt evidence-based and research-based practices includes:

- Ongoing training and consultation with model developers
- Adjustment to service cost, reflecting increased work associated with participating in fidelity, consultation, and any possible new work associated with the model
- CA staff resources needed to implement, manage, and support the change in contracts

Table 6: New Service Year One Development and Cost

Current Contracted Service	Training Group	Start-up Training	Yearly Fidelity Support	Yearly Cost Adjustment	TOTAL
Parent-Child Visitation	30 Parent Coaches	$25,000	$5,000	$640,000[3]	$670,000
Early Family Support Service (EFSS)	24 Therapists	$46,000	$12,000	None - Relocation	$29,000
Child Placing Agencies (CPA)	20 Facilitators	$100,000	$18,000	$385,000[4]	$503,000

[3] *To fund higher* hourly rate for P*arent Coaches*
[4] *A New Service Provided by CPA'*

Children's Administration is currently moving forward with the recommendations for expanding current evidence-based or research-based practices and increasing service completion rates.

Finally, two additional full time equivalent HQ staff is needed to develop the resources and infrastructure to implement these new EBPs.

Juvenile Justice and Rehabilitation Administration (JJ&RA)

The juvenile justice recommendations for increasing the delivery of evidence-based and research-based programs above the baseline assessment are as follows:

- Functional Family Parole (new funding)
- Functional Family Therapy (reallocation)
- Functional Family Therapy (new funding)
- Drug Court (existing funding – not included in baseline assessment)
- Evidence-based and research-based programs for Becca youth (new funding)

Functional Family Parole (FFP)

Over 395 youth were released from a Juvenile Rehabilitation residential program without any parole aftercare in State Fiscal Year 2013. A 2011 study by the Research and Data Analysis (RDA) division of DSHS indicated youth released without parole aftercare services were 48 percent more likely to be re-arrested during the nine months following release. Additionally, the youth without parole aftercare services were 55 percent less likely to be employed, and if they were, they made significantly less money than youth with parole aftercare.

In March of 2009, The Center for Adolescent and Family Studies out of the University of Indiana published an interim outcome evaluation of JR's Functional Family Parole (FFP). Functional Family Parole (FFP) is evidence based, strengths focused, and family centered supervision model. Parole Counselors using FFP principles project an attitude of respect, develop a balanced alliance with all family members, and strive to reduce negative, blaming feelings and interactions between family members by reframing the issue into a relational focus. This approach helps families improve how they work together to accomplish family goals and reduce the youth's risk to reoffend. Some of the key findings of the study are as follows:

- At 12 months following release from an institution there is a 17.9 percent reduction in felony crime and at 18 months a 15.31 percent reduction in recidivism rates for those youth who received highly adherent FFP as compared to a matched control group. These rates do not reflect a statistically significant difference.
- At 12 months post release youth in the FFP group had significantly fewer parole revocations as compared to traditional parole services. FFP youth have 14.7 percent fewer parole revocations.
- At 12 months post parole, those youth with above average pre-crime severity index scores who received the FFP intervention had significantly lower post-parole crime severity behavior indicating that the most difficult youth received more benefit from FFP.
- Parents and youth who received FFP reported improvements in their overall family functioning, youth behavior, parental supervision, family communication, as well as reductions in family conflict.

Recommendation

The baseline report indicated that 320 youth received FFP in 2012. The recommendation is to increase the delivery of FFP to all eligible youth. This would allow approximately 660 youth to receive FFP each year, which would equal a 107 percent increase in youth served in FFP. This recommendation will require new funding from the Legislature to accomplish.

Program	New Annual Participants	Funding Required	Funding Classification	Percentage Increase
Functional Family Parole (FFP)	340	$2,266,000	New Funding	107%

Functional Family Therapy (FFT)

Functional Family Therapy (FFT) is an empirically grounded, well documented and highly successful family intervention program for at-risk and delinquent youth 11-18 years of age. FFT has been applied to a wide range of youth and their families in various multi-ethnic and multicultural contexts. Target populations range from at-risk preadolescents to youth with very serious problems including: conduct disorder, violent externalizing behaviors and substance abuse.

In January of 2004, the Washington State Institute for Public Policy (WSIPP) conducted an outcome evaluation of FFT. Some of the key findings of that study are as follows:

- 38 percent reduction in felony recidivism
- Cost savings ratio – for every $1 invested, $10.69 will be saved when the intervention is delivered by competent therapists
- If the intervention is not delivered competently, it can make the youth worse

The baseline report indicated that 645 juvenile justice youth participated in FFT in 2012. The recommendation is to **reallocate funding** and to request new funding to serve more youth and families in FFT.

Beginning in State Fiscal Year 2013, JR reallocated funding to expand its delivery of FFT by funding an additional 1.5 FTE to provide FFT to youth on parole. This reallocation will allow approximately 681 youth in total to receive FFT each year, which would equal a six percent increase in youth served in FFT.

Program	New Annual Participants	Funding Required	Funding Classification	Percentage Increase
Functional Family Therapy (FFT)	36	$98,457	Reallocation	6%

The recommendation for **new funding** for FFT is related to the JR Functional Family Parole funding request. If new funding for FFP is granted, and 340 additional youth are able to receive parole aftercare, many of these youth will be eligible for FFT. As a result, the recommendation is to expand the delivery of FFT by funding an additional 2.0 FTE to provide FFT to youth on parole. This new funding will allow approximately 729 youth in total to receive FFT each year, which would equal a seven percent increase in youth served in FFT.

Program	New Annual Participants	Funding Required	Funding Classification	Percentage Increase
Functional Family Therapy (FFT)	48	$131,276	New Funding	7%

Juvenile Drug Courts

Selected delinquency cases, and in some instances status offenders who are identified as having problems with alcohol and/or other drugs are referred to a Juvenile Drug Court docket with a designated judge. Over the course of up to a year or more, the youth, family, providers, and probation meet frequently (often weekly), determining how best to address the substance abuse and related problems of the youth and his or her family that brought the youth into contact with the juvenile justice system.

Juvenile drug courts are on the Inventory of Evidence-Based, Research-Based, and Promising Practices created by the University of Washington's Evidence Based Practice Institute (EBPI) and the WSIPP in September 2012 and updated in June 2013. However, due to a variety of factors, juvenile drug courts were not included in the baseline report. Although State funding is provided to some juvenile drug courts, the majority of funding comes from the local counties. A major factor is the ability to collect data on youth served by State funding.

Recommendation

Currently there are 12 juvenile courts offering a drug court. Of those 12 drug courts, five receive state funding. The recommendation is to develop a reporting system so data and information can be collected and reported as described in the HB 2536 baseline report requirements. Juvenile drug courts will be included in follow-up reports to the Legislature, as outlined in the HB 2536, in years 2014 and 2015.

There is no funding needed at this time for this recommendation.

Evidence-Based and Research-Based Programs for Becca Youth

Following the tragic death of 13-year-old Rebecca Hedman, a truant youth and runaway from Tacoma, Washington, the Washington State Legislature passed a law known as the "Becca Bill" in 1995. The intent of the truancy provisions of the Becca Law was to curb truancy before it becomes a major problem in the life of a youth.

The Becca Bill

The Becca Bill was designed for parents to gain assistance from the courts to support their at-risk teenagers. The youth involved are often using or abusing substances, chronically run from the home, present mental health concerns, or are involved in other activities which directly endanger themselves or others. Parents, children, courts, law enforcement and CA use this legislation to respond to family conflicts and assist families in crisis management and reconciliation.

The Becca Bill consists of three petitions:

- At Risk Youth (ARY)
- Child in Need of Services (CHINS)
- Truancy

At Risk Youth (ARY)

Through this process parents may petition the courts for assistance with their teen while the teen resides in their home. Court orders mandate the youth attend school, remain at home, abstain from all drug/alcohol use, follow a curfew, and potentially a list of other case by case directives. For a child to meet the requirements of an ARY petition they must meet at least one of three criteria:

- An individual who is under 18 and remains absent from the home for a period of more than 72 hours without parental consent
- Is beyond parental control such that behavior endangers the health, safety or welfare of the child or another person
- Has a serious substance abuse problem

Child in Need of Services (CHINS)

The purpose of a CHINS petition is to temporarily place a child outside of the home in an attempt to repair family relationships and ensure child safety. This temporary placement is only able to last 6 – 9 months and the petitioning party must provide placement. CHINS petitions can be filed by a parent, youth, or DSHS. Under a CHINS petition, the parent and the child are often required to attend counseling which includes family and individual counseling. Visitation between the parents and child occurs, along with a host of other possible services, to seek family reconciliation at the end of the 6 – 9 month period.

Truancy

These petitions are typically filed by school officials and schools are mandated to file if a youth had seven unexcused absences in one month or ten in one year. These petitions require the youth to attend school every day, every period, on time and can also hold the parent responsible for chronic truancy.

Prevalence Study

In September of 2011, the National Center for Juvenile Justice conducted a study that examined the prevalence of multi-system involvement (specifically, child welfare and Becca) among youth referred to the King County Juvenile Court on offender matters during the 2006 calendar year. Some of the key findings of that study are as follows:

- Overall, 72 percent of all youth referred to the King County Juvenile Court in 2006 on offender matters had some history of Becca petition filings and/or history of CA involvement (either prior, during or subsequent to calendar year 2006).
- The percentage of youth with a history of Becca petition filings and/or CA involvement increases to 95 percent for youth referred on two or more offender referrals prior to CY2006.
- There is a strong correlation between recidivism and history of Becca/CA involvement.

Washington State Becca Task Force

Founded in 2002, the Washington State Becca Task Force is a statewide voluntary organization chaired by and comprised of statewide leaders, including legislators, judges, prosecutors, defense attorneys, law enforcement, educators, treatment providers, and court administrators. The mission of the Becca Task Force is to help keep kids in school and out of the juvenile justice system by promoting the intent, goals and outcomes of the Washington State Becca Laws. These goals include: providing early and appropriate interventions for truancy to assist school-aged youth with reengaging in school and staying out of the juvenile justice system; ensuring adequate funding for the courts, schools, and programs that implement the intent of the Becca legislation; sharing research and best practices for truancy prevention and intervention; and collaborating on statewide Becca reform efforts through the coordinated efforts of members and the implementation of targeted strategies.

The Becca Task Force has developed a set of recommendations for truancy system reform in Washington State, prioritized in 5 subject areas:

1. Funding for Implementation of the State's Becca/ Truancy Laws
2. Monitoring of Outcomes and Student Success
3. Early Intervention, Utilization of Court as a Last Resort and Reduction in the Use of Secure Detention in Truancy Cases
4. Affirmative Steps toward Reengagement of Youth in Education
5. Statewide Collaboration and Coordination through the Leadership of the State's ESDs

Under subject area three, the Becca Task Force recommended the following:

> To ensure that appropriate interventions are employed, screening and assessment instruments should be administered to identify known indicators that are predictive of truancy, delinquency, and dropping out, at the first signs of problematic behavior by a youth and prior to a truancy petition filing. **Interventions should be administered early and based on best, promising, and proven practices that are evidence or research-based**.

In 2011, there were 13,258 CHINS, ARY, and Truancy petitions filed in Washington State. Currently, the juvenile courts do not receive State funding to serve Becca youth with evidence-based or research-based programming.

Recommendation

The recommendation is for new funding for juvenile courts to offer up to three evidence-based or research-based programs to Becca youth and their families: Aggression Replacement Training (ART), Functional Family Therapy (FFT), and Multi-Systemic Therapy (MST). Based on the number of petitions filed each year it is challenging to determine the actual number of annual participants. If funding is provided for evidence-based and research-based programs for Becca youth the juvenile courts would utilize the same cost structures[5] used for probation and diversion youth.

[5] The Becca recommendation is based on half of the petitions filed in 2011 (13,258) being eligible (6,629) for one of the three evidence-based and research-based programs (ART, FFT, and MST). Utilizing the same percentage breakdown of all probation and diversion youth that received these programs in SFY 2013: ART – 53%, FFT – 22%, and MST – 2%; the new annual participants were calculated. The costs per participant were derived from the WSIPP 2009 report *"Providing Evidence-Based Programs with Fidelity in Washington State Juvenile Courts: Cost Analysis*". The costs used for this recommendation are: ART - $1,558, FFT - $3,370, MST - $7,608. This is only to provide a financial base for the recommendation, and additional information will be necessary to more accurately capture these budget assumptions.

Programs	New Annual Participants	Funding Required	Funding Classification	Percentage Increase
Aggression Replacement Training (ART)	3,505	$5,460,790	New Funding	135%
Functional Family Therapy (FFT)	1,446	$4,873,020	New Funding	135%
Multi-Systemic Therapy (MST)	160	$1,217,280	New Funding	135%

Juvenile Justice Programs – Continuous Quality Improvement

Implementation of evidence-based and research-based programs requires a commitment to maintaining a program's integrity by working to remain adherent and competent in the delivery of those programs. In order to effectively increase the utilization of evidence-based and research-based programs the following core elements must be present:

- Quality Assurance
- Program Research and Analysis
- Promising Programs

Quality Assurance

In December of 2003, WSIPP, as directed by the Legislature, published a report titled Recommended Quality Control Standards: Washington State Research-Based Juvenile Offender Programs (page 2). In their review of the implementation of research-based programs, WSIPP concluded the following:

> *Since the late 1990s, Washington has been recognized as a leader in implementing research-based juvenile justice programs. After evaluating Washington's experiences to date, one conclusion is clear: these programs work, but with one vital qualification. When the programs do not adhere to the original design, they can fail. In fact, we found that the programs can increase the recidivism rates of participants when they are poorly delivered.*

This report was the catalyst for the juvenile justices' current quality assurance structures. Every program that was listed in the juvenile justice baseline report has some form of quality assurance. Quality assurance is an ever-evolving process where data and information assist with decision making and change.

One thing is for certain, quality assurance and monitoring for fidelity takes funding and resources. Since 2004, the juvenile justice field has been building a robust system of quality assurance. This has largely been accomplished without specific funding support from the Legislature. The juvenile courts receive state funding from the Legislature. Funding for quality assurance is taken off the top of those direct service dollars before they are distributed to the juvenile courts. JR received some funding to support quality assurance for their residential programs but it was not funded at nearly the capacity at which it needs to be. Currently there are only two FTEs dedicated to providing training and quality assurance to all JR residential staff. Despite these challenges, juvenile justice understands the immense value in these efforts. However, with specific funding assistance for quality assurance more youth could be served and

the quality of services received would drastically improve leading to even better outcomes for youth and families.

Recommendation

Fidelity and quality assurance is an integral part of the delivery of evidence-based and research-based programs. The recommendation is for new funding to be provided to the level necessary to ensure programs are being implemented and delivered as they are intended. Without quality assurance and fidelity monitoring the State's investment in these programs will not meet expectations.

Program Research and Analysis

It is essential that funding for program expansion include funds necessary to conduct research on those programs that fall into the category of promising or research based. Strong data analysis regarding youth within the juvenile justice system will improve the system's ability to select programs that work.

A broader array of well-designed and effective programs is necessary in order to respond to the needs of those youth that are not being reached by the current menu of programs. The juvenile justice system is not yet in a position to fully respond with programs designed to meet the needs of youth based on cultural differences or on differences in the complexity of youth needs.

Research Needs and Conclusions

For nearly 15 years the Washington State Legislature has been committed to the ongoing prioritization of evidence-based programming for the juvenile justice system. More recently, pursuant to House Bill 2536, this effort has been enlarged to include a similar emphasis for different systems of care including children in the mental health and child welfare systems. With the legislature's support to date, and the work of juvenile justice agencies, Washington State is perceived as a national leader in the areas of providing evidence-based programs in juvenile justice and for the quality assurance structure created to ensure the programs are implemented and maintained to create positive results for the youth served.

The continued success of this evidence-focused juvenile justice system depends on the willingness of those who govern directional and budgetary decisions to meet the needs of the system so that it can move forward. It is time for Washington State to expand beyond implementation, maintenance and quality assurance monitoring of our programs. The next phase of our commitment includes the ability to evaluate in detail our current menu of evidence-based and research-based programs and make data driven decisions regarding possible new programs that could meet the needs of those children with whom we have yet to succeed. Without a commitment to full research support for evidence-based programs in juvenile justice the current system of care will become outdated, unresponsive to important new information, and ultimately less successful. To continue to use funding identified for direct service of programs to support this necessary piece of the overall picture translates into fewer and fewer youth getting into programs, completely defeating the purpose of this evidence-based journey.

Currently, the funds allocated for juvenile justice evidenced-based programs are fully dedicated to program delivery and its quality assurance structure. A strong research foundation is needed that will help lawmakers determine if Washington State is maximizing its tax dollars to reduce crime. State professionals in juvenile justice, both juvenile courts and JR, identify this as an important priority.

While the current need for responsive research in juvenile justice is critical, it is only wise to see this as part of a long-term strategy that should be able to serve not only legislators and juvenile justice professionals but also those other systems of care now starting down the path of providing evidence-based

programs to their consumers. All systems should be able to take advantage of a learned truth: that evidence-based programs cannot thrive on their own, creating positive outcomes for any target population without the underpinning of skilled professionals, competent providers of programs, quality assurance experts and the science of research.

Recommendation

At a minimum, future steps to expand the menu of evidence-based and research-based programs must include costs for evaluation, data analysis and research.

Costs for these items will vary by program. Choosing which programs to prioritize for implementation will require additional data analysis about the risks and needs of youth in the juvenile justice system. Special consideration should be made for youth that appear to have needs that are not met by currently available programs.

Promising Programs

As mentioned previously, the juvenile justice field has been investing in evidence-based and research-based programs for many years. What this journey has uncovered is that not all youth can be adequately served by the menu of programs that are currently provided. After reviewing the baseline report for juvenile justice it became very clear there are two very specific treatment areas that do not have an evidence-based or research-based treatment available: substance abuse treatment and sex offender treatment. In the juvenile courts funding for these two treatments are the only areas where treatment funding is spent on a non-evidence-based or research-based program. This is consistent with JR as well.

Another area of focus for promising practices is mentoring. The juvenile justice field is invested in this program and it is currently listed as a promising program.

Recommendation

This baseline follow-up report is specifically aimed at strategies and recommendations to increase the delivery of evidence-based and research-based programs. The juvenile justice field needs to extend beyond what is currently available. As a result, in order to effectively implement promising programs, new funding will need to be made available to provide quality assurance and fidelity monitoring as well as funding for research and data analysis.

The elements for this recommendation were previously mentioned relating to evidence-based and research-based programs (quality assurance and research). A sound investment is critical in order to ensure promising programs are being done with fidelity, have a research design, and a plan for evaluation.

Health Care Authority (HCA)

Unlike DBHR, CA, and JJ&RA, Medicaid's relationship with the mental health providers who render these services is not analogous to the employer-employee or contracted model with extensive contractual obligations. Medicaid does not regulate the delivery of their care, Medicaid reimburses for service rendered. Therefore, in the absence of data, HCA is in the unique position of being able to replicate a proven, successful HCA data collection model affiliated with the claims process.

Implementation and Resources

HCA will develop a billing procedure for collecting information on which E/RBPs are being provided to Medicaid FFS clients and will implement by January 1, 2014. Because the payment is based on the procedure code per Centers for Medicaid and Medicare Services (CMS), there is no change in reimbursement; therefore, HCA does not anticipate any increase in cost. In addition, because the data collection methodology is already part of the existing ProviderOne programming, no additional funds are required for programming changes.

Timeline

Once data is recorded and reportable, HCA will have the opportunity to analyze what mental health practitioners are rendering E/RBPs and to what extent clients are receiving E/RBPs and which ones. To support the expansion of E/RBPs provided to Medicaid clients, HCA will utilize the "Report Card" approach which shares data about practitioner's practices and compares it with their peer group to incentivize adoption of best practices among the members of the provider group.

Approaches for Prioritizing Promising Practices

The goal of a promising practice is to move into the category of research-based and evidence-based.

A cross system workgroup was formed to develop a prioritization process for these practices. The workgroup met over a six month period and developed a prioritization process. The process was shared with the University of Washington EBPI to solicit feedback and recommendations.

While DSHS and HCA support the expanded use of research and evidence based practices across services and programs, considerable cost and time commitments are required to bring a promising practice up to the standards of research-based and evidence-based. DSHS and HCA have carefully balanced the resources needed for E/RBP expansion with the resources needed to increase the number of promising practices that meet the standards for evidence-based and research-based. The June 2013 "Inventory of Evidence-Based, Research-Based and Promising Practices" lists 29 promising practices. DSHS is very willing to help support applications submitted by promising practices to obtain research funding, but DSHS and HCA (with current funding) will be able to directly prioritize only one or two practices at most for the in-depth assessment needed to meet E/RBP standards.

The prioritization process developed by DSHS and HCA takes the promising practices identified by the University of Washington and looks for practices that serve a population or need that is not addressed by existing E/RBPs. These can include a diagnosis that is not addressed, the needs of a special population, or special needs and considerations for children served in rural areas. The process then reviews the available promising practices to make sure that they serve a meaningful portion of youth in services, fit with DSHS and HCA values, and have been developed enough for implementation and evaluation to effectively occur.

The next steps for this cross system workgroup are as follows:

1. Charter Development—develop a charter that includes cross system representation and key external representation to inform the work plan and direction of E/RBPs in the state.
2. Work plan—establish regular meetings to identify, strategize and put forward best E/RBPs to meet the needs of those underrepresented children/youth within the state.

3. Engage stakeholders and governments—Work in partnership with stakeholders, governments and children/youth/families to ensure the work is informed by these instrumental voices.

Next Steps

DSHS and HCA will provide updated recommendations to the governor and the legislature by December 30, 2014, and December 30, 2015.

If DSHS or HCA anticipate they will not meet their recommended levels for an upcoming biennium as set forth in its report, they must report to the legislature by November 1 of the year preceding the biennium. This report shall include:

1. The identified impediments to meeting the recommended levels
2. The current and anticipated performance level
3. Strategies that will be undertaken to improve performance

DSHS and HCA are eager to expand the use of E/RBPs. This report illustrates many opportunities where we can expand and increase delivery of E/RBPs. Much of our expansion is dependent upon new funding directed toward resource training, rates and infrastructure enhancement.

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